

Corporate Creations Network Inc.
 801 US Highway 1 North Palm Beach, FL 33408

Publix Asset Management Company
 Merriann Metz General Counsel & Secretary
 Publix Super Markets Inc.
 3300 Publix Corporate Parkway
 Lakeland FL 33811

12/14/2021

SERVICE OF PROCESS NOTICE

The following is a courtesy summary of the enclosed document(s). **ALL information should be verified by you.**

Item: 2021-10641

Note: Any questions regarding the substance of the matter described below, including the status or how to respond, should be directed to the contact set forth in line 12 below or to the court or government agency where the matter is being heard. **IMPORTANT:** All changes or updates to the SOP contact individuals or their contact information must be submitted in writing to SOPcontact@corpcreations.com. Any changes will become effective upon written confirmation of Corporate Creations.

1.	Entity Served:	Publix Asset Management Company
2.	Title of Action:	Angelica Cruz-Romo, et al. vs. Publix Super Markets, Inc.; et al.
3.	Document(s) Served:	Summons Complaint Exhibits Plaintiff's First Set of Interrogatories and Requests for Production
4.	Court/Agency:	Davidson County Circuit Court
5.	State Served:	Tennessee
6.	Case Number:	21C2157
7.	Case Type:	Negligence/Personal Injury
8.	Method of Service:	Hand Delivered
9.	Date Received:	Monday 12/13/2021
10.	Date to Client:	Tuesday 12/14/2021
11.	# Days When Answer Due: Answer Due Date:	30 Wednesday 01/12/2022 CAUTION: Client is solely responsible for verifying the accuracy of the estimated Answer Due Date. To avoid missing a crucial deadline, we recommend immediately confirming in writing with opposing counsel that the date of the service in their records matches the Date Received.
12.	Sop Sender: (Name, City, State, and Phone Number)	Michael K. Parsley Goodlettsville, TN 615-749-6127
13.	Shipped To Client By:	Regular Mail and Email with PDF Link
14.	Tracking Number:	
15.	Handled By:	431
16.	Notes:	None

NOTE: This notice and the information above is provided for general informational purposes only and should not be considered a legal opinion. The client and their legal counsel are solely responsible for reviewing the service of process and verifying the accuracy of all information. At Corporate Creations, we take pride in developing systems that effectively manage risk so our clients feel comfortable with the reliability of our service. We always deliver service of process so our clients avoid the risk of a default judgment. As registered agent, our role is to receive and forward service of process. To decrease risk for our clients, it is not our role to determine the merits of whether service of process is valid and effective. It is the role of legal counsel to assess whether service of process is invalid or defective. Registered agent services are provided by Corporate Creations Network Inc.

801 US Highway 1 North Palm Beach, FL 33408 Tel: (561) 694-8107 Fax: (561) 694-1639
 www.CorporateCreations.com

CIRCUIT COURT SUMMONS

NASHVILLE, TENNESSEE

Service ID 266475

**STATE OF TENNESSEE
DAVIDSON COUNTY
20TH JUDICIAL DISTRICT**

ANGELICA CRUZ-ROMO , et al.

Plaintiff

**CIVIL ACTION
DOCKET NO. 21C2157
Method of Service:
Williamson County Sheriff**

vs.

**PUBLIX ASSET MANAGEMENT COMPANY
205 POWELL PLACE
C/O CORPORATE CREATIONS NET
BRENTWOOD, TN 37027**

Defendant


To the above named Defendant:

You are summoned to appear and defend a civil action filed against you in the Circuit Court, 1 Public Square, Room 302, P.O. Box 196303, Nashville, TN 37219-6303 , and your defense must be made within thirty (30) days from the date this Summons is served upon you. You are further directed to file your defense with the Clerk of the Court and send a copy to the Plaintiff's attorney at the address listed below.

In case of your failure to defend this action by the above date, judgment by default will be rendered against you for the relief demanded in the Complaint.

ISSUED: 12/06/2021

RICHARD R. ROOKER
Circuit Court Clerk
Davidson County, Tennessee

By: 

Deputy Clerk

ADDRESS OF PLAINTIFF'S ATTORNEY OR PLAINTIFF:

**MICHAEL K. PASLEY PARSLEY
400 PROFESSIONAL PARK DRIVE
GOODLETTSVILLE, TN 37072**

NOTICE TO THE DEFENDANT:

Tennessee law provides a Ten Thousand and 00/100 Dollars (\$10,000.00) debtor's equity interest personal property exemption from execution or seizure to satisfy a judgment. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the Clerk of the Court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary wearing apparel (clothing) for yourself and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible, and school books. Should any of these items be seized, you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer.



To request an ADA accommodation, please contact Dart Gore at (615) 880-3309

CIRCUIT COURT SUMMONS

NASHVILLE, TENNESSEE

Service ID 266475

STATE OF TENNESSEE
DAVIDSON COUNTY
20TH JUDICIAL DISTRICT

ANGELICA CRUZ-ROMO , et al.

Plaintiff

vs.

PUBLIX ASSET MANAGEMENT COMPANY
205 POWELL PLACE
C/O CORPORATE CREATIONS NET
BRENTWOOD, TN 37027

Defendant

CIVIL ACTION
DOCKET NO. 21C2157
Method of Service:
Out of County Sheriff

RETURN ON PERSONAL SERVICE OF SUMMONS

I hereby certify and return that on the _____ day of _____, 20____, I:

_____ served this Summons and Complaint/Petition on _____ in the following manner:

_____ failed to serve this Summons within 90 days after its issuance because _____

Sheriff/Process Server



To request an ADA accommodation, please contact Dart Gore at (615) 880-3309

IN THE CIRCUIT COURT OF DAVIDSON COUNTY, TENNESSEE

ANGELICA CRUZ-ROMO and
ROGELIO GARCIA

Plaintiffs,

V.

**PUBLIX SUPER MARKETS,
INC., PUBLIX ASSET
MANAGEMENT COMPANY, and
PUBLIX TENNESSEE, LLC.**

Defendants.

JURY DEMAND

Docket No. _____

BEFORE THE HONORABLE

COMPLAINT

COME NOW PLAINTIFFS and for their complaint against Defendants state:

1. Plaintiffs Angelica Cruz-Romo and Rogelio Garcia, a married couple, are citizens and residents of Davidson County, Tennessee.
2. Defendant Publix Super Markets, Inc. is a Florida corporation with a principal office located at 3300 Publix Corporate Parkway, Lakeland, Florida 33811.
3. Defendant Publix Super Markets, Inc. may be served with process through its registered agent, Corporate Creations Network, Inc., 205 Powell Place, Brentwood, Williamson County, Tennessee 37027-7522.
4. Defendant Publix Tennessee, LLC is a Florida limited liability company with a principal office located at 3300 Publix Corporate Parkway, Lakeland, Florida 33811.
5. Defendant Publix Tennessee, LLC may be served with process through its registered agent, Corporate Creations Network, Inc., 205 Powell Place, Brentwood, Williamson County, Tennessee 37027-7522.
6. Defendant Publix Asset Management company is a Florida corporation with a principal office located at 3300 Publix Corporate Parkway, Lakeland, Florida 33811.

7. Defendant Publix Asset Management Company may be served with process through its registered agent, Corporate Creations Network, Inc., 205 Powell Place, Brentwood, Williamson County, Tennessee 37027-7522.

8. Plaintiff's cause of action arises out of a January 30, 2021, incident in which Plaintiff Angelica Cruz-Romo suffered serious injuries as a result of being struck by a lifting cart and/or other machinery owned and operated by Defendants on the premises of Defendants' commercial establishment, the Publix Supermarket located at 3532 Murfreesboro Pike, Antioch, Davidson County, Tennessee 37013.

9. This Court has jurisdiction over this cause pursuant to Tenn. Code Ann. § 16-10-101.

10. Venue is proper pursuant to Tenn. Code Ann. § 20-4-104, as the events and omissions giving rise to this cause of action occurred in Davidson County.

11. At all times relevant herein, Defendants owned and operated the Publix Supermarket Mt. View marketplace located at 3532 Murfreesboro Pike, Antioch, Davidson County, Tennessee 37013 ("Publix 1235").

12. At all times relevant herein, Plaintiff Angelica Cruz-Romo was exercising reasonable care for her own safety.

13. On or about January 30, 2021, Plaintiff Angelica Cruz-Romo was shopping at Publix 1235.

14. Plaintiff Angelica Cruz-Romo was waiting for a prescription when she was struck by a lifting cart and/or other machinery owned and operated by Defendants' employees, agents, or servants.

15. The lifting cart and/or other machinery was being operated by Defendants' employees, agents, or servants, who were acting in the course and scope of their employment at the time of the incident.

16. Defendants had a duty to exercise reasonable care in the operation of the lifting cart and/or machinery.

17. Defendants failed to exercise reasonable care in the operation of the lifting cart and/or machinery, causing it to strike Plaintiff Angelica Cruz-Romo.

18. As a result of being struck by the lifting cart and/or other machinery, Plaintiff Angelica Cruz-Romo suffered serious injuries.

19. As a result of the incident, Plaintiff Rogelio Garcia has suffered the loss of consortium, companionship, society, and affection usually enjoyed in the marital relationship with his wife, Plaintiff Angelica Cruz-Romo.

20. As a direct and proximate result of one or more acts of negligence and/or recklessness of Defendants, Plaintiffs are entitled to compensation for the following damages:

- a. Physical pain, both past and future;
- b. Emotional suffering and grief, both past and future;
- c. Health care expenses, both past and future;
- d. Loss of enjoyment of life;
- e. Permanent impairment and partial disability;
- f. Loss of consortium;
- g. Loss of earning capacity;
- h. Lost wages;
- i. Costs of this cause; and

- j. All other general damages and other relief allowed under the laws of the State of Tennessee.

PRAYER

WHEREFORE, PLAINTIFFS PRAY:

1. For process to issue and be served upon Defendants, requiring Defendants to answer the allegations herein;
2. For a jury to be empaneled to try this cause;
3. For a judgment in favor of Angelica Cruz-Romo against Defendants for compensatory damages in an amount to be determined by the jury but not to exceed \$200,000.00;
4. For a judgment in favor of Romelio Garcia against Defendants for compensatory damages in an amount to be determined by the jury but not to exceed \$50,000.00;
5. For costs of this action to be taxed to Defendants; and
6. For such other, further, and general relief as this Court deems just and proper.

Respectfully submitted,

MICHAEL D. PONCE & ASSOCIATES, PLLC

BY:


MICHAEL K PARSLEY, BPR No. 023817

400 Professional Park Drive
Goodlettsville, Tennessee 37072

Phone: (615) 749-6127

Fax: (615) 859-7033

michaelp@poncelaw.com

Counsel for Plaintiffs

TWO RIVERS EMERG PHYS, PLLC
PO BOX 37983
PHILADELPHIA, PA 19101-7983

MMI

STATEMENT OF ACCOUNT (0)

Page 1

Statement Date: 08/09/21

TAX ID# 46-3901187
131309-0002262915400-01
#BWNJFDB
#000000MMI9189489#
ANGELICA CRUZ ROMO
1712 BIRDSONG CHASE DRIVE
ANTIOCH, TN 37013

Account Number: MMI002262915400
Patient Name: ANGELICA CRUZ ROMO

Services provided at:

TRISTAR SUMMIT MEDICAL CENTER - 5655 FRIST BLVD - HERMITAGE TN 37076-2053

Date of Service	Referral	Description	Provider	Charge
01/20/2021	00294	EMERG INJURY EVAL & MGMT-LVL 4	DR. GREEN	\$1,148.00
01/20/2021	00294	EMERG INJURY EVAL & MGMT-LVL 4	DR. GREEN	\$1,148.00
01/20/2021	00294	EMERG INJURY EVAL & MGMT-LVL 4	DR. GREEN	\$1,148.00
01/20/2021	00294	EMERG INJURY EVAL & MGMT-LVL 4	DR. GREEN	\$1,148.00
01/20/2021	00294	EMERG INJURY EVAL & MGMT-LVL 4	DR. GREEN	\$1,148.00
01/20/2021	00294	EMERG INJURY EVAL & MGMT-LVL 4	DR. GREEN	\$1,148.00
01/20/2021	00294	EMERG INJURY EVAL & MGMT-LVL 4	DR. GREEN	\$1,148.00
01/20/2021	00294	EMERG INJURY EVAL & MGMT-LVL 4	DR. GREEN	\$1,148.00
01/20/2021	00294	EMERG INJURY EVAL & MGMT-LVL 4	DR. GREEN	\$1,148.00
01/20/2021	00294	EMERG INJURY EVAL & MGMT-LVL 4	DR. GREEN	\$1,148.00

Total Charges: \$1,221.00

2/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk

**PLAINTIFF'S
EXHIBIT
A**
FILED

PATIENT NO: 226291540 SUMMIT MEDICAL CENTER BILLING DATE PAGE 1 00025
 HED REC NO: 372921 3655 FRIST BOULEVARD 02/03/21
 GUARANTOR NO:
 PATIENT: HERMITAGE TN 370762053 ADMITTED DISCHARGED
 GARCIA ANGELICA 01/30/21 01/30/21

PAY TO ADDRESS: SUMMIT MEDICAL CENTER
 PO BOX 402551
 ATLANTA
 GA 303842551

BILL TO:
 GARCIA ANGELICA EMERGENCY FC-08
 1712 BIRDSONG CHASE DRIV ADMIT THRU DISCHARGE CLAIM
 ANTIOCH TN
 37013

DATE OF SERVICE	BATCH REF	F DEPT S	PRGC	NDC/CPT-4/ HCPCS	QTY SERVICE DESCRIPTION	CHARGES	
301-LAB/CHEMISTRY							
013021	30B998	0736	802140	80053	1 COMP METABOLIC PANEL	705.80	
						SUBTOTAL:	705.80
305-LAB/HEMATOLOGY							
013021	30B998	0736	800270	85027	1 CBC AUTOMATED	327.18	
						SUBTOTAL:	327.18
307-LAB/UROLOGY							
013021	30B998	0736	600509	81001	1 UA W MICRO AUTO	170.01	
						SUBTOTAL:	170.01
352-CT SCAN/BODY							
013021	30B002	0726	325952	74177	1 CT ABD&PELVIS W/CONT	12531.53	
						SUBTOTAL:	12531.53
450-EMERG ROOM							
013021	01B209	0780	319041	99284	1 LVL 4 EMER DEPT	2442.16	
						SUBTOTAL:	2442.16
636-DRUGS/DETAIL CODE							
013021	30B002	0718	065909	Q9967	100 LOCK 300-399 IC 100ML	104.00	
						SUBTOTAL:	104.00
TOTAL ANCILLARY CHARGES						16280.68	

FILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk

PATIENT NO:	226291540	SUNNIT MEDICAL CENTER	BILLING DATE	PAGE	2	00025
ED REC NO:	372921	5655 FRIST BOULEVARD	02/03/21			
GUARANTOR NO:						
PATIENT:		HERMITAGE	TN 370762053	ADMITTED		DISCHARGED
GARCIA ANGELICA				01/30/21		01/30/21

TOTAL CHARGES 16280.68

FILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk

PATIENT NO:	226291S40	SUNNIT MEDICAL CENTER	BILLING DATE	PAGE	3	00025
HED REC NO:	372921	5655 FRIST BOULEVARD	02/03/21			
GUARANTOR NO:						
PATIENT:		HERMITAGE	TN 370762053	ADMITTED		DISCHARGED
GARCIA ANGELICA				01/30/21		01/30/21

DEPARTMENTAL CHARGE SUMMARY		
DEPT	DESCRIPTION	AMOUNT
0718	MATERIALS MANAGEMENT	104.00
0726	CT SCAN	12,531.53
0736	LABORATORY	1,202.99
0780	EMERGENCY ROOM	2,442.16

REVENUE CHARGE SUMMARY		TOTAL
REV CD	DESCRIPTION	
0301	LAB/CHEMISTRY	705.80
0305	LAB/HEMATOLOGY	327.18
0307	LAB/UROLOGY	170.01
0352	CT SCAN/BODY	12,531.53
0450	EMERG ROOM	2,442.16
0636	DRUGS/DETAIL CODE	104.00

TOTAL CHARGES: 16,280.68

FILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk

SUMMIT MEDICAL CENTER		SUMMIT MEDICAL CENTER		226291540			
5655 FRIST BOULEVARD		PO BOX 402551		000000372921		0131	
HERMITAGE TN 370762053		ATLANTA GA30384		62-1113737		013021 013021	
6158864788							
PATIENT NAME		PATIENT ADDRESS		1712 BIRDSONG CHASE DRIV			
GARCIA, ANGELICA		ANTIOCH		TN		37013	
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[object Object]

RADIOLOGY ALLIANCE PC
P O BOX 440166
NASHVILLE TN 37244-0166
(800) 475-6112

Patient:

Acct #: 930148
GARCIA, ANGELICA
1712 BIRDSONG CHASE DRIVE
ANTIOCH, TN 37013

Srvc. Date	CPT	Proc. Description	Charge
01/30/2021	74177	CT, ABD AND PEL; W/ CONT	\$311.00
01/30/2021	G9637	FINAL REPORTS WITH DOCUM	\$0.00

Reproduced: Tuesday,

FILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk

1. MEDICARE <input type="checkbox"/> (Medicare)		MEDICAID <input type="checkbox"/> (Medicaid)		TRICARE <input type="checkbox"/> (TRICARE)		CHAMP/VA <input type="checkbox"/> (CHAMP/VA)		GROUP HEALTH PLAN <input checked="" type="checkbox"/> (GROUP HEALTH PLAN)		FICA BACKLUNG <input type="checkbox"/> (FICA BACKLUNG)		OTHER <input type="checkbox"/> (OTHER)													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cruz Romo Angelica						3. PATIENT'S BIRTH DATE 03 05 1988		4. SEX M		5. PATIENT RELATIONSHIP TO INSURED Self															
6. PATIENT'S ADDRESS (No., Street) 1712 Birdsong Chase						7. CITY Antioch		8. STATE TN		9. RESERVED FOR NUCC USE															
10. ZIP CODE 37013-1178						11. TELEPHONE (Include Area Code) ()						12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)													
13. OTHER INSURED'S POLICY OR GROUP NUMBER						14. EMPLOYMENT? (Current or Previous) YES						15. AUTO ACCIDENT? YES													
16. RESERVED FOR NUCC USE						17. OTHER ACCIDENT? YES						18. CLAIM CODES (Designated by NUCC)													
19. INSURANCE PLAN NAME OR PROGRAM NAME						20. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.						21. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Sign for the patient or authorized person or agent to process this claim. I also request payment of government benefits either to myself or to the party who is acting as my agent below.) Signature On File													
22. SIGNED						23. DATE 04/23/21						24. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (If Applicable) MM DD YY													
25. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Beckus PA Michael TN						26. OTHER DATE MM DD YY						27. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO													
28. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						29. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO						30. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO													
31. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Report ICD-9-CM code below (245)) S38012D M545 M546						32. PRIOR AUTHORIZATION NUMBER						33. BILLING PROVIDER'S NAME Seven Spines Orthopedics PC													
34. A. DATE(S) OF SERVICE 04142021 04142021						35. B. PLACE OF SERVICE (SN) 11						36. C. PROCEDURE, SERVICE, OR SUPPLY (CPT/HCPCS) 97182 GP		37. D. DIAGNOSIS POINTER A		38. E. CHARGES 250 00		39. F. UNITS OR LOTS 1		40. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.		41. TOTAL CHARGE 250 00		42. BILLING PROVIDER'S NAME Seven Spines Orthopedics PC	
43. SIGNATURE OF PROVIDER OR SUPPLIER (Including signature of provider or supplier) Stokovich, Jeremy						44. DATE 04/23/2021						45. BILLING PROVIDER'S NAME Seven Spines Orthopedics PC													
46. BILLING PROVIDER'S ADDRESS 5300 Hickory Hollow Pkwy Suite 201						47. BILLING PROVIDER'S CITY Antioch TN						48. BILLING PROVIDER'S STATE 37013-3117													
49. BILLING PROVIDER'S ZIP CODE 37013-3117						50. BILLING PROVIDER'S PHONE 1194210005						51. BILLING PROVIDER'S FAX 1194210005													

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BENEFIT OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Cruz Romo Angelica

3. PATIENT'S BIRTH DATE
03 05 1999 SEX ☒ F ☐ M

5. PATIENT'S ADDRESS (No. Street)
1712 Birdsong Chase

6. PATIENT RELATIONSHIP TO INSURED
Self ☒ Spouse ☐ Child ☐ Other ☐

7. RESERVED FOR MUCC USE

8. CITY
Antioch STATE
TN

9. ZIP CODE
37013-1176 TELEPHONE (include Area Code)
()

10. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

11. OTHER INSURED'S POLICY OR GROUP NUMBER

12. RESERVED FOR MUCC USE

13. RESERVED FOR MUCC USE

14. INSURANCE PLAN NAME OR PROGRAM NAME

15. IS PATIENT'S CONDITION RELATED TO

16. EMPLOYMENT? (Current or Previous)
☐ YES ☒ NO

17. AUTO ACCIDENT?
☐ YES ☒ NO PLACE (State)

18. OTHER ACCIDENT?
☐ YES ☒ NO

19. CLAIM CODES (Designated by MUCC)

NEAR BACK OF FORM BEFORE COMPLETING & SENDING THIS FORM.

1. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)

SIGNED **Signature On File** DATE **04/23/21**

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)
MM DD YY
QUAL

15. OTHER DATE
QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
DN Beckus PA Michael TN

18. IDENTIFICATION NUMBER
17a **1114900131**

19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A, L, H service line below (2+E)) ICD-9-CM **0**

A **S39012D** B **M545** C **M548** D

E F G H

I J K L

24. A	24. B	24. C	24. D	24. E	24. F	24. G	24. H	24. I	24. J
DATE OF SERVICE	DATE OF SERVICE	PLACE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	DIAGNOSIS (ICD-9-CM)	CHARGES	DAYS OR LESS	PERCENTAGE PAID	RENDERING PROVIDER IN	
04/20/2021	04/20/2021	11	97110 GP	A	70.00	1		1487135281	
04/20/2021	04/20/2021	11	97112 GP	A	100.00	1		1487135281	
04/20/2021	04/20/2021	11	97140 GP	A	85.00	1		1487135281	
04/20/2021	04/20/2021	11	97530 GP, 50	A	80.00	1		1487135281	

25. TOTAL CHARGE
335.00

26. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this form apply to this bill and are made a part thereof.)
Stojakovich, Jeremy
04/23/2021

27. SERVICE FACILITY LOCATION INFORMATION
SSO Antioch
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117

28. BILLING PROVIDER (P.O. Box)
Seven Springs Orthopedics PC
5301 Virginia Way Suite 155
Brentwood TN 37027-7542

SIGNED **1184210005** DATE

MUCC Instruction Manual available at: www.nunc.org PLEASE PRINT OR TYPE CRO61653 APPROVED OMB 0938-1197 FORM 1500 (12-12)

PCAT
CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
FILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> SELF (LUNG) <input type="checkbox"/> OTHER <input type="checkbox"/>		2. PATIENT'S BIRTH DATE 05/05/1966		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
3. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cruz Romo Angelica		4. PATIENT'S ADDRESS (No, Street) 1712 Birdsong Chase		5. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6. CITY Antioch		7. STATE TN		8. RESERVED FOR MUCC USE	
9. ZIP CODE 37013-1176		10. TELEPHONE (Include Area Code) ()		11. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
12. OTHER INSURED'S POLICY OR GROUP NUMBER		13. RESERVED FOR MUCC USE		14. RESERVED FOR MUCC USE	
15. RESERVED FOR MUCC USE		16. RESERVED FOR MUCC USE		17. RESERVED FOR MUCC USE	
18. INSURANCE PLAN NAME OR PROGRAM NAME		19. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20. CLAIM CODES (Designated by MUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (i.e., obtain the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment of benefits.) Signature On File SIGNED: _____ DATE: 05/10/21					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM DD YY) QUAL: _____		15. OTHER DATE QUAL: _____ MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR Backus PA Michael TN		17a. _____ 17b. NPI: 1444000434		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-C to service line below (ONE) A. S30012D B. M545 C. M546 D. _____ E. _____ F. _____ G. _____ H. _____					
22. PRIOR AUTHORIZATION NUMBER					
23. PRIOR AUTHORIZATION NUMBER					
24. A. DATES OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. CPT/HCPCS D. PROCEDURES, SERVICE, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS F. S CHARGES G. S CHARGES H. S CHARGES I. S CHARGES J. S CHARGES K. S CHARGES L. S CHARGES M. S CHARGES N. S CHARGES O. S CHARGES P. S CHARGES Q. S CHARGES R. S CHARGES S. S CHARGES T. S CHARGES U. S CHARGES V. S CHARGES W. S CHARGES X. S CHARGES Y. S CHARGES Z. S CHARGES					
25. TOTAL CHARGE 335.00					
26. SIGNATURE OF PROVIDER OR SUPPLIER Stojakovich, Jeremy 05/10/2021					
27. SIGNATURE OF FACILITY LOCATION INFORMATION SSO Antioch 6380 Hickory Hollow Pkwy Suite 201 Antioch TN 37013-3117					
28. SIGNATURE OF PHYSICIAN OR SUPPLIER Seven Springs Orthopedics PC 5301 Virginia Way Suite 155 Brentwood TN 37027-7642					

FILED 12/06/21 10:34 AM CASE NO. 2:12-cv-00012 Richard R. Rooker, Clerk

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA (FELA) <input type="checkbox"/> OTHER <input type="checkbox"/> (Patient #) (Medical #) (SOP/COI) (Member ID) (ID#) (ID#) (ID#)																																																																																																																																																															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cruz Romo Angelica					3. PATIENT'S BIRTH DATE 08:05:1990 SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M																																																																																																																																																										
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Table A-L to service this holder (SNF)) S39012D M545 M545					22. REFERRAL CODE ORIGINAL REF NO 																																																																																																																																																										
23. PRIOR AUTHORIZATION NUMBER 					24. TOTAL CHARGE 200.00																																																																																																																																																										
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3">A. DATES OF SERVICE</th> <th colspan="2">B. PLACE OF SERVICE</th> <th colspan="2">C. FMS</th> <th colspan="2">D. PROCEDURE, SERVICE, OR SUPPLIES (Specify Unusual Circumstances)</th> <th>E. DIAGNOSIS</th> <th>F. CHARGES</th> <th>G. DAYS</th> <th>H. ICD-9</th> <th>I. ICD-10</th> <th>J. RENDERING PROVIDER ID #</th> </tr> <tr> <th>MM</th><th>DD</th><th>YY</th> <th>MM</th><th>DD</th><th>YY</th> <th>PT</th><th>CD</th><th>NUMBER</th> <th>NUMBER</th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>04</td><td>27</td><td>2021</td> <td>04</td><td>27</td><td>2021</td> <td>11</td> <td></td> <td>97140 GP</td> <td>A</td> <td>170.00</td> <td>2</td> <td></td> <td></td> <td>1487136281</td> </tr> <tr> <td>04</td><td>27</td><td>2021</td> <td>04</td><td>27</td><td>2021</td> <td>11</td> <td></td> <td>97014 GP</td> <td>A</td> <td>30.00</td> <td>1</td> <td></td> <td></td> <td>1487136281</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>										A. DATES OF SERVICE			B. PLACE OF SERVICE		C. FMS		D. PROCEDURE, SERVICE, OR SUPPLIES (Specify Unusual Circumstances)		E. DIAGNOSIS	F. CHARGES	G. DAYS	H. ICD-9	I. ICD-10	J. RENDERING PROVIDER ID #	MM	DD	YY	MM	DD	YY	PT	CD	NUMBER	NUMBER						04	27	2021	04	27	2021	11		97140 GP	A	170.00	2			1487136281	04	27	2021	04	27	2021	11		97014 GP	A	30.00	1			1487136281																																																																																										
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25. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof.) Stokolsky, Jeremy 05/10/2021					26. SET FOR CLAIM INFORMATION SSO Antioch 5380 Hickory Hollow Pkwy Suite 201 Antioch TN 37013-3117					27. SET FOR CLAIM INFORMATION Seven Springs Orthopedics PC 5301 Virginia Way Suite 155 Brentwood TN 37027-7542																																																																																																																																																					
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CARRIER
PAC
PATIENT AND INSURED INFORMATION
Rooker, Clerk
CASE NO. 21C2157
FILED 12/06/21 10:34 AM

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

FILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN PECA (BLU LINK) OTHER <input type="checkbox"/> (Medicare ID) <input type="checkbox"/> (Medicaid ID) <input type="checkbox"/> (JCA-DAID) <input type="checkbox"/> (Champion ID) <input type="checkbox"/> (Group ID) <input type="checkbox"/> (PECA ID) <input type="checkbox"/> (BLU LINK ID) <input type="checkbox"/> (Other ID)		2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cruz Romo Angelica		3. PATIENT'S BIRTH DATE 06:05:1999		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
4. PATIENT'S ADDRESS (No. Street) 1712 Birdsong Chase		5. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		6. RESERVED FOR NUCC USE		7. RESERVED FOR NUCC USE	
CITY Antioch		STATE TN		8. RESERVED FOR NUCC USE		9. RESERVED FOR NUCC USE	
ZIP CODE 37013-1178		TELEPHONE (Include Area Code) ()		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10d. CLAIM CODES (Designated by NUCC)		11. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I declare the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment before.) Signature On File		13. DATE 05/10/21		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) MM/DD/YY QUAL		15. OTHER DATE MM/DD/YY QUAL	
16. NAME OF BILLING PROVIDER OR OTHER SOURCE DR Backus PA Michael TN		17a. 1144000131		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY		19. OUTSIDE LAST YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include ICD-10 code) S39012D M545 M545 ICD-10		22. REQUISITION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATES OF SERVICE From MM/DD/YY To MM/DD/YY		B. PLACE OF SERVICE BMS		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Dates and Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POSTER	
F. CHARGES		G. DENT UNIT		H. ICD-10 QUAL		I. J. RENDERING PROVIDER ID #	
1 04302021 04302021 11 97110 GP A 70.00 1 1487138281		2 04302021 04302021 11 97140 GP A 179.00 2 1487138281		3 04302021 04302021 11 97014 GP A 30.00 1 1487138281		4	
5		6		7		8	
9		10		11		12	
13		14		15		16	
17		18		19		20	
21		22		23		24	
25		26		27		28	
29		30		31		32	
33		34		35		36	
37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
73		74		75		76	
77		78		79		80	
81		82		83		84	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		100	

28. TOTAL CHARGE
270.00

29. SIGNATURE OF BILLING PROVIDER
Stojakovich, Jeremy
05/10/2021

30. SIGNATURE OF SUPPLIER
SSO Wood
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117

31. SIGNATURE OF PHYSICIAN
SEVEN SPRINGS Orthopedics PC
5301 Virginia Way Suite 155
Brentwood TN 37027-7642

SIGNED DATE 1184210005

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1600C S-12

1. MEDICARE MEDIGAP TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA	OTHER
(Medicare #) (Medigap #) (TRICARE #)	(Member ID#)	(Plan #)	(FECA #)	(Other #)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cruz-Romo Angelica		3. PATIENT'S BIRTH DATE 08 05 1989		
5. PATIENT'S ADDRESS (No. & Street) 1712 Birdsong Chase		6. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		
CITY Antioch	STATE TN	8. RESERVED FOR NUCC USE		
ZIP CODE 37013-1178	TELEPHONE (Include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
d. INSURANCE PLAN NAME OR PROGRAM NAME		10a. CLAIM CODES (Designated by NUCC)		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)

SIGNED: **Signature On File** DATE: **05/10/21**

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) MM DD YY	15. OTHER DATE (MM/DD/YY) MM DD YY
QUAL: DN Backus PA Michael TN	QUAL: 1114900431

16. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Indicate A-C to service line below (ONE)	
A. S30012D	B. M545
C. M545	D.
E. 	F.
G. 	H.
I. 	J.

24. A. DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unit and Description)		E.
From To				PLACE OF SERVICE	ICD-9			DIAGNOSIS ICD-9
MM	DD	YY	MM	DD	YY			
05	04	2021	05	04	2021	11	97110 GP	A
05	04	2021	05	04	2021	11	97112 GP	A
05	04	2021	05	04	2021	11	97140 GP	A
05	04	2021	05	04	2021	11	97014 GP	A

18. DAYS PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
--	--

20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	22. PRIOR AUTHORIZATION NUMBER
23. CHARGE	24. CHARGE

25. TOTAL CHARGE 370 00	26. TOTAL CHARGE 370 00
-----------------------------------	-----------------------------------

INCLUDING SIGNATURE OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made in good faith.)

Stojakovich, Jeremy
05/10/2021

SSO Antioch
6380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117

Seven Springs Orthopedics P.C.
6301 Virginia Way Suite 155
Brentwood TN 37027-7542

FILED 12/06/21 10:34 AM CASE NO. 2:12-cv-00012 Richard R. Rooker, Clerk

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
Rooker, Clerk
FILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R.

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN RECA (Other) OTHER	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cruz Romo Angelica	
3. PATIENT'S BIRTH DATE 03/05/1989	
4. PATIENT'S ADDRESS (No. Street) 1712 Birdsong Chase	
5. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6. RESERVED FOR NUCC USE	
7. CITY Antioch	
8. STATE TN	
9. ZIP CODE 37013-1176	
10. TELEPHONE (Include Area Code) ()	
11. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
12. OTHER INSURED'S POLICY OR GROUP NUMBER	
13. RESERVED FOR NUCC USE	
14. RESERVED FOR NUCC USE	
15. INSURANCE PLAN NAME OR PROGRAM NAME	
16. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. CLAIM CODES (Designated by NUCC)	
17. SIGNATURE ON FILE 05/20/21	
18. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) MM DD YY QUAL 19. OTHER DATE MM DD YY QUAL	
20. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Beckus PA Michael TN	
21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Indicate A1 to service line below (N/A)) A. S30012D B. M546 C. M546 D. E. F. G. H. 	
23. A. DATES OF SERVICE From To MM DD YY MM DD YY B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLY (Specify Medical Code) D. ICD-9 CODE E. DIAGNOSIS F. CHARGE G. DEX H. ICD I. DUAL J. PROVIDER K. PROVIDER ID #	
1. 05132021 05132021 11 97110 GP A 70 00 1 NPI 1487135281	
2. 05132021 05132021 11 97112 GP A 100 00 1 NPI 1487135281	
3. 05132021 05132021 11 97140 GP A 85 00 1 NPI 1487135281	
4. 05132021 05132021 11 97530 GP, 59 A 80 00 1 NPI 1487135281	
5. 05132021 05132021 11 97014 GP A 30 00 1 NPI 1487135281	
6. TOTAL CHARGE 365 00	
24. BILLING PROVIDER INFORMATION SSO Antioch 5380 Hickory Hollow Pkwy Suite 201 Antioch TN 37013-3117	
25. BILLING PROVIDER INFORMATION Seven Springs Orthopedics PC 6301 Virginia Way Suite 155 Brentwood TN 37027-7542	
26. SIGNATURE Stojakovich, Jeremy 05/20/2021	
27. DATE 05/20/2021	
28. CLAIM NUMBER 1104210005	

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input checked="" type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Check one)</small>											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cruz-Romo Angelica						3. PATIENT'S BIRTH DATE 03/05/1989					
5. PATIENT'S ADDRESS (No. Street) 1712 Birdsong Chase						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
CITY Antioch				STATE TN		8. RESERVED FOR NUCC USE					
ZIP CODE 37013-1178				TELEPHONE (Include Area Code) () () ()							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:					
11. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
12. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> PLACE (State) <input type="text"/>					
13. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. INSURANCE PLAN NAME OR PROGRAM NAME						15. CLAIM CODES (Designated by NUCC)					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Indicate the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) Signature On File DATE 05/20/21											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (M.P.) MM DD YY QUAL				15. OTHER DATE MM DD YY QUAL				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR Backus PA Michael TN				17a. NPI 1114800131				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES				21. RE submission CODE ORIGINAL REF. NO.			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Indicate A-L in service line below (ONE)) A. S30012D B. M545 C. M546 D. Q E. F. G. H. I. J. K. L. 				22. PRIOR AUTHORIZATION NUMBER				23. PRIOR AUTHORIZATION NUMBER			
24. A. DATES OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE SIC		C. PROCEDURE, SERVICE, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS MODIFIER		D. DIAGNOSIS PORTER		E. CHARGES		F. CHARGES	
1 05/18/21 05/18/21		11		97110 GP		A		70.00 1		1487135281	
2 05/18/21 05/18/21		11		97112 GP		A		100.00 1		1487135281	
3 05/18/21 05/18/21		11		97140 GP		A		85.00 1		1487135281	
4 05/18/21 05/18/21		11		97530 GP 50		A		80.00 1		1487135281	
5											
6											
25. TOTAL CHARGE 335.00						26. PAYOR INFORMATION SSO Antioch 5380 Hickory Hollow Pkwy Suite 201 Antioch TN 37013-3117					
27. PROVIDER INFORMATION Stojakovich, Jeremy 05/20/2021						28. PAYOR INFORMATION Seven Springs Orthopedics PC 5301 Virginia Way Suite 155 Brentwood TN 37027-7542					
SIGNED DATE						1194210005					

CARRIER
PAC ()
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
FILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FICA <input type="checkbox"/> OVER <input type="checkbox"/>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cruz Romo Angelica	
3. PATIENT'S BIRTH DATE 03/06/1989 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
4. PATIENT'S ADDRESS (St., Street) 1712 Birdsong Chase	
5. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6. RESERVED FOR NUCC USE	
7. CITY Antioch STATE TN	
8. ZIP CODE 37013-1176 TELEPHONE (Include Area Code) () () ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO	
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) <input type="checkbox"/>	
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
11. CLAIM CODES (Designated by NUCC)	
12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Indicates the absence of any medical or other information necessary to process the claim. Also request payment of government benefits prior to receipt of the party who accepts management fees) Signature On File DATE 08/10/21	
14. DATE OF CURRENT ILLNESS, INJURY, OR FRESHWATER (LMP) <input type="checkbox"/> QUAL. <input type="checkbox"/> MM DD YY	
15. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION <input type="checkbox"/> FROM <input type="checkbox"/> TO <input type="checkbox"/>	
16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES <input type="checkbox"/> FROM <input type="checkbox"/> TO <input type="checkbox"/>	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR Beckus PA Michael TN 17a. 1114900131 17b. NP1	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
19. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
20. DIAGNOSIS ON NATURE OF ILLNESS OR INJURY, Re: A-4 to service the below (SHE) ICD 10 0	
21. PRIOR AUTHORIZATION NUMBER	
22. TOTAL CHARGE 335 00	
23. BILLING PROVIDER'S & P.L.S. Seven Springs Orthopedics PC 5301 Virginia Way Suite 155 Brentwood TN 37027-7542	
24. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Stojkovich, Jeremy 08/10/2021	
25. SERVICE FACILITY LOCATION INFORMATION SSO Antioch 5380 Hickory Hollow Pkwy Suite 201 Antioch TN 37013-3117	
26. BILLING PROVIDER'S & P.L.S. 1194210005	
27. NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 0838-1197 FORM 1500 (02/12)	

CARRIER
PAYER AND INSURED INFORMATION
ROUTER, CLERK
FILED 12/06/21 10:34 AM PIONEER SUPPLIES INFORMATION

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		TRICARE <input type="checkbox"/> (TRICARE #)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (Group #)		PECA <input type="checkbox"/> (PECA #)		OTHER <input type="checkbox"/> (Other #)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cruz Romo Angelica						3. PATIENT'S BIRTH DATE 03/05/1989						SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F					
5. PATIENT'S ADDRESS (No. Street) 1712 Birdsong Chase						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						8. RESERVED FOR NUCC USE					
CITY Antioch				STATE TN													
ZIP CODE 37013-1178				TELEPHONE (Include Area Code) ()													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)											
11. OTHER INSURED'S POLICY OR GROUP NUMBER																	
12. RESERVED FOR NUCC USE																	
13. RESERVED FOR NUCC USE																	
14. INSURANCE PLAN NAME OR PROGRAM NAME																	
15. SIGNATURE OF PATIENT OR AUTHORIZED PERSON'S SIGNATURE (I warrant the accuracy of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment of benefits.) Signature On File DATE 06/10/21																	
16. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (MM/DD/YY) MM DD YY QUAL						17. OTHER DATE MM DD YY QUAL						18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
19. NAME OF RECEIVING PROVIDER OR OTHER SOURCE DN Backus PA Michael TN						17a. NPI 1114900131						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO & CHARGES						22. PRIOR AUTHORIZATION NUMBER 48103					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please A-L to describe the below (SHE)) A. S39012D B. M546 C. M546 D. Q E. F. G. H. I. J. K. L.						23. PRIOR AUTHORIZATION NUMBER 48103											
24. A. DATES OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) MODIFIER		D. DIAGNOSIS POWER		E. CHARGES		F. DAYS OF WEEK		G. PRO/PT		H. ID. QUAL		I. RENDERING PROVIDER ID. #	
1 05272021 06272021		11		97110 GP		A		70 00 1						NPI		1487135281	
2 05272021 06272021		11		97112 GP		A		100 00 1						NPI		1487135281	
3 05272021 06272021		11		97140 GP		A		85 00 1						NPI		1487135281	
4 05272021 06272021		11		97530 GP 59		A		80 00 1						NPI		1487135281	
5														NPI			
6														NPI			
25. TOTAL CHARGE 335 00						26. BILLING PROVIDER INFO (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z) Seven Springs Orthopedics PC 6301 Virginia Way Suite 155 Brentwood TN 37027-7542											
27. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on this invoice apply to the bill and are made in good faith.) Stokovich, Jeremy 06/10/2021						28. SERVICE FACILITY LOCATION INFORMATION 550 Antioch 6380 Hickory Hollow Pkwy Suite 201 Antioch TN 37013-3117						29. BILLING PROVIDER INFO (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z) 1194210005					
27. SIGNED 06/10/2021						28. DATE 06/10/2021						29. APPROVED OMB 0633-1197 FORM 1500 (02-12)					

CARRIER
PICA
PATIENT AND INSURED INFORMATION
Rooker, Clerk
FILED 12/06/21 10:34 AM PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FICA BLK LUND <input type="checkbox"/> OTHER <input type="checkbox"/>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cruz Romo Angelica	
3. PATIENT'S BIRTH DATE 03/05/1989 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
4. PATIENT'S ADDRESS (St, Street) 1712 Birdsong Chase	
5. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6. RESERVED FOR NUCC USE	
7. RESERVED FOR NUCC USE	
8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10a. CLAIM CODES (Designated by NUCC)	
11. INSURANCE PLAN NAME OR PROGRAM NAME	
12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either in my name or in the name of the designated assignment below. Signature On File DATE 08/10/21 SIGNED _____ DATE _____	
14. DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP) MM DD YY 15. OTHER DATE MM DD YY	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE DR Backues PA Michael TN 17a. NPI 1114800131	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (From A-L, in service line below (I-4E)) A. S39012D B. M545 C. M546 D. U E. U F. U G. U H. U I. U J. U K. U L. U	
22. RESUBMISSION CODE ORIGINAL REF NO	
23. PRIOR AUTHORIZATION NUMBER 48103	
24. A. DATES OF SERVICE From To B. PLACE OF SERVICE C. CPT/HCPCS D. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances) E. DIAGNOSIS F. CHARGES G. DATE OF SERVICE H. ICD-9-CM I. RENDERING PROVIDER ID #	
1 08012021 08012021 11 97110 GP A 70 00 1 NPI 1487135281	
2 08012021 08012021 11 97112 GP A 100 00 1 NPI 1487135281	
3 08012021 08012021 11 97530 GP A 180 00 2 NPI 1487135281	
4	
5	
6	
25. TOTAL CHARGE 330 00	
26. BILLING PROVIDER (S) & PH # Seven Springs Orthopedics PC 5301 Virginia Way Suite 155 Brentwood TN 37027-7542	
27. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include NPI, DPMPS or CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made in good faith).) Stokovich, Jeremy 08/10/2021	
28. SERVICE FACILITY LOCATION INFORMATION SSO Antioch 5380 Hickory Hollow Pkwy Suite 201 Antioch TN 37013-3117	
29. BILLING PROVIDER ID # 1194210005	
SIGNED _____ DATE _____	

1. MEDICARE		2. MEDICAID		3. TRICARE		4. CHAMPVA		5. GROUP HEALTH PLAN		6. FECA		7. OTHER	
8. PATIENT'S NAME (Last Name, First Name, Middle Initial)		9. PATIENT'S BIRTH DATE		10. SEX		11. PATIENT'S ADDRESS (No. Street)		12. PATIENT RELATIONSHIP TO INSURED		13. RESERVED FOR NUCC USE		14. RESERVED FOR NUCC USE	
Cruz Romo Angelica		03/05/1980		M		1712 Birdsong Chase		Spouse					
15. CITY		16. STATE		17. ZIP CODE		18. TELEPHONE (Include Area Code)		19. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		20. OTHER INSURED'S POLICY OR GROUP NUMBER		21. RESERVED FOR NUCC USE	
Antioch		TN		37013-1178		()							
22. IS PATIENT'S CONDITION RELATED TO:		23. EMPLOYMENT? (Current or Previous)		24. AUTO ACCIDENT?		25. PLACE (State)		26. OTHER ACCIDENT?		27. YES		28. NO	
		YES		YES		TN		YES		YES		NO	
29. INSURANCE PLAN NAME OR PROGRAM NAME		30. CLAIM CODES (Designated by NUCC)		31. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY)		32. OTHER DATE		33. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		34. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		35. OUTSIDE LAB?	
				08/10/21				FROM TO		FROM TO		YES NO	
36. SIGNATURE ON FILE		37. DATE		38. NAME OF REFERRING PROVIDER OR OTHER SOURCE		39. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		40. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Per A.L. to service the below (IME))		41. ICD-9-CM		42. PRIOR AUTHORIZATION NUMBER	
08/10/21				DN Backus PA Michael TN				S39012D M545 M548		Q		48103	
43. A. DATE(S) OF SERVICE		44. B. PLACE OF SERVICE		45. C. PROCEDURE, SERVICE, or SUPPLY		46. D. DIAGNOSIS		47. E. CHARGES		48. F. DAYS OF USE		49. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
From To		BMS		CPT/HCPCS		ICD-9-CM		S CHARGES		Days of Use		H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
08032021 08032021		11		97110 GP		A		70.00 1		NPI		1487135281	
08032021 08032021		11		97112 GP		A		100.00 1		NPI		1487135281	
08032021 08032021		11		97530 GP		A		180.00 2		NPI		1487135281	
										NPI			
										NPI			
										NPI			
										NPI			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & P.O. #		34. TOTAL CHARGE		35. SIGNATURE OF PATIENT		36. DATE		37. APPROVED	
Strickovich, Jeremy		SSO Antioch		Seven Springs Orthopedics PC		330.00				08/10/21		1194210005	
08/10/21		5380 Hickory Hollow Pkwy Suite 201		6301 Virginia Way Suite 165									
		Antioch TN 37013-3117		Brentwood TN 37027-7542									

PCA ☐

CARRIER

PATIENT AND INSURED INFORMATION

SUPPLIER INFORMATION

FILED 12/06/21 10:34 AM CASE NO. 21-02157 Richard R. Rooker, Clerk

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> PFC/LONG <input type="checkbox"/> OTHER <input type="checkbox"/>		2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Cruz Romo Angelica		3. PATIENT'S BIRTH DATE 05/05/1999		4. PATIENT'S ADDRESS (City, State) Antioch TN		5. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6. PATIENT'S ADDRESS (City, State) 1712 Birdsong Chase		7. PATIENT'S BIRTH DATE 05/05/1999		8. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		9. RESERVED FOR NUCC USE		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
11. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) _____		12. OTHER INSURED'S POLICY OR GROUP NUMBER _____		13. RESERVED FOR NUCC USE		14. RESERVED FOR NUCC USE		15. INSURANCE PLAN NAME OR PROGRAM NAME _____	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Indicate the release of any medical or other information necessary to process this claim. I also accept payment of government benefits either to myself or to the party who accepts assignment.) Signature On File DATE 08/10/21									
17. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) MM DD YY		18. OTHER DATE MM DD YY		19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21. PRIOR AUTHORIZATION NUMBER 48103	
22. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Beckus PA Michael TN		23. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		24. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Please A-L to service line below (PMS) ICD-10)		25. RESUBMISSION CODE _____		26. PRIOR AUTHORIZATION NUMBER 48103	
27. A. DATE OF SERVICE From MM DD YY To MM DD YY		27. B. PLACE OF SERVICE _____		27. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		27. D. DIAGNOSIS _____		27. E. RENDERING PROVIDER ID # 1487135281	
28. A. DATE OF SERVICE From MM DD YY To MM DD YY		28. B. PLACE OF SERVICE _____		28. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		28. D. DIAGNOSIS _____		28. E. RENDERING PROVIDER ID # _____	
29. A. DATE OF SERVICE From MM DD YY To MM DD YY		29. B. PLACE OF SERVICE _____		29. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		29. D. DIAGNOSIS _____		29. E. RENDERING PROVIDER ID # _____	
30. A. DATE OF SERVICE From MM DD YY To MM DD YY		30. B. PLACE OF SERVICE _____		30. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		30. D. DIAGNOSIS _____		30. E. RENDERING PROVIDER ID # _____	
31. A. DATE OF SERVICE From MM DD YY To MM DD YY		31. B. PLACE OF SERVICE _____		31. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		31. D. DIAGNOSIS _____		31. E. RENDERING PROVIDER ID # _____	
32. A. DATE OF SERVICE From MM DD YY To MM DD YY		32. B. PLACE OF SERVICE _____		32. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		32. D. DIAGNOSIS _____		32. E. RENDERING PROVIDER ID # _____	
33. A. DATE OF SERVICE From MM DD YY To MM DD YY		33. B. PLACE OF SERVICE _____		33. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		33. D. DIAGNOSIS _____		33. E. RENDERING PROVIDER ID # _____	
34. A. DATE OF SERVICE From MM DD YY To MM DD YY		34. B. PLACE OF SERVICE _____		34. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		34. D. DIAGNOSIS _____		34. E. RENDERING PROVIDER ID # _____	
35. A. DATE OF SERVICE From MM DD YY To MM DD YY		35. B. PLACE OF SERVICE _____		35. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		35. D. DIAGNOSIS _____		35. E. RENDERING PROVIDER ID # _____	
36. A. DATE OF SERVICE From MM DD YY To MM DD YY		36. B. PLACE OF SERVICE _____		36. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		36. D. DIAGNOSIS _____		36. E. RENDERING PROVIDER ID # _____	
37. A. DATE OF SERVICE From MM DD YY To MM DD YY		37. B. PLACE OF SERVICE _____		37. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		37. D. DIAGNOSIS _____		37. E. RENDERING PROVIDER ID # _____	
38. A. DATE OF SERVICE From MM DD YY To MM DD YY		38. B. PLACE OF SERVICE _____		38. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		38. D. DIAGNOSIS _____		38. E. RENDERING PROVIDER ID # _____	
39. A. DATE OF SERVICE From MM DD YY To MM DD YY		39. B. PLACE OF SERVICE _____		39. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		39. D. DIAGNOSIS _____		39. E. RENDERING PROVIDER ID # _____	
40. A. DATE OF SERVICE From MM DD YY To MM DD YY		40. B. PLACE OF SERVICE _____		40. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		40. D. DIAGNOSIS _____		40. E. RENDERING PROVIDER ID # _____	
41. A. DATE OF SERVICE From MM DD YY To MM DD YY		41. B. PLACE OF SERVICE _____		41. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		41. D. DIAGNOSIS _____		41. E. RENDERING PROVIDER ID # _____	
42. A. DATE OF SERVICE From MM DD YY To MM DD YY		42. B. PLACE OF SERVICE _____		42. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		42. D. DIAGNOSIS _____		42. E. RENDERING PROVIDER ID # _____	
43. A. DATE OF SERVICE From MM DD YY To MM DD YY		43. B. PLACE OF SERVICE _____		43. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		43. D. DIAGNOSIS _____		43. E. RENDERING PROVIDER ID # _____	
44. A. DATE OF SERVICE From MM DD YY To MM DD YY		44. B. PLACE OF SERVICE _____		44. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		44. D. DIAGNOSIS _____		44. E. RENDERING PROVIDER ID # _____	
45. A. DATE OF SERVICE From MM DD YY To MM DD YY		45. B. PLACE OF SERVICE _____		45. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		45. D. DIAGNOSIS _____		45. E. RENDERING PROVIDER ID # _____	
46. A. DATE OF SERVICE From MM DD YY To MM DD YY		46. B. PLACE OF SERVICE _____		46. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		46. D. DIAGNOSIS _____		46. E. RENDERING PROVIDER ID # _____	
47. A. DATE OF SERVICE From MM DD YY To MM DD YY		47. B. PLACE OF SERVICE _____		47. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		47. D. DIAGNOSIS _____		47. E. RENDERING PROVIDER ID # _____	
48. A. DATE OF SERVICE From MM DD YY To MM DD YY		48. B. PLACE OF SERVICE _____		48. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		48. D. DIAGNOSIS _____		48. E. RENDERING PROVIDER ID # _____	
49. A. DATE OF SERVICE From MM DD YY To MM DD YY		49. B. PLACE OF SERVICE _____		49. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		49. D. DIAGNOSIS _____		49. E. RENDERING PROVIDER ID # _____	
50. A. DATE OF SERVICE From MM DD YY To MM DD YY		50. B. PLACE OF SERVICE _____		50. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		50. D. DIAGNOSIS _____		50. E. RENDERING PROVIDER ID # _____	
51. A. DATE OF SERVICE From MM DD YY To MM DD YY		51. B. PLACE OF SERVICE _____		51. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		51. D. DIAGNOSIS _____		51. E. RENDERING PROVIDER ID # _____	
52. A. DATE OF SERVICE From MM DD YY To MM DD YY		52. B. PLACE OF SERVICE _____		52. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		52. D. DIAGNOSIS _____		52. E. RENDERING PROVIDER ID # _____	
53. A. DATE OF SERVICE From MM DD YY To MM DD YY		53. B. PLACE OF SERVICE _____		53. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		53. D. DIAGNOSIS _____		53. E. RENDERING PROVIDER ID # _____	
54. A. DATE OF SERVICE From MM DD YY To MM DD YY		54. B. PLACE OF SERVICE _____		54. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		54. D. DIAGNOSIS _____		54. E. RENDERING PROVIDER ID # _____	
55. A. DATE OF SERVICE From MM DD YY To MM DD YY		55. B. PLACE OF SERVICE _____		55. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		55. D. DIAGNOSIS _____		55. E. RENDERING PROVIDER ID # _____	
56. A. DATE OF SERVICE From MM DD YY To MM DD YY		56. B. PLACE OF SERVICE _____		56. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		56. D. DIAGNOSIS _____		56. E. RENDERING PROVIDER ID # _____	
57. A. DATE OF SERVICE From MM DD YY To MM DD YY		57. B. PLACE OF SERVICE _____		57. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		57. D. DIAGNOSIS _____		57. E. RENDERING PROVIDER ID # _____	
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59. A. DATE OF SERVICE From MM DD YY To MM DD YY		59. B. PLACE OF SERVICE _____		59. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		59. D. DIAGNOSIS _____		59. E. RENDERING PROVIDER ID # _____	
60. A. DATE OF SERVICE From MM DD YY To MM DD YY		60. B. PLACE OF SERVICE _____		60. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		60. D. DIAGNOSIS _____		60. E. RENDERING PROVIDER ID # _____	
61. A. DATE OF SERVICE From MM DD YY To MM DD YY		61. B. PLACE OF SERVICE _____		61. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		61. D. DIAGNOSIS _____		61. E. RENDERING PROVIDER ID # _____	
62. A. DATE OF SERVICE From MM DD YY To MM DD YY		62. B. PLACE OF SERVICE _____		62. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		62. D. DIAGNOSIS _____		62. E. RENDERING PROVIDER ID # _____	
63. A. DATE OF SERVICE From MM DD YY To MM DD YY		63. B. PLACE OF SERVICE _____		63. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		63. D. DIAGNOSIS _____		63. E. RENDERING PROVIDER ID # _____	
64. A. DATE OF SERVICE From MM DD YY To MM DD YY		64. B. PLACE OF SERVICE _____		64. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		64. D. DIAGNOSIS _____		64. E. RENDERING PROVIDER ID # _____	
65. A. DATE OF SERVICE From MM DD YY To MM DD YY		65. B. PLACE OF SERVICE _____		65. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		65. D. DIAGNOSIS _____		65. E. RENDERING PROVIDER ID # _____	
66. A. DATE OF SERVICE From MM DD YY To MM DD YY		66. B. PLACE OF SERVICE _____		66. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		66. D. DIAGNOSIS _____		66. E. RENDERING PROVIDER ID # _____	
67. A. DATE OF SERVICE From MM DD YY To MM DD YY		67. B. PLACE OF SERVICE _____		67. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		67. D. DIAGNOSIS _____		67. E. RENDERING PROVIDER ID # _____	
68. A. DATE OF SERVICE From MM DD YY To MM DD YY		68. B. PLACE OF SERVICE _____		68. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		68. D. DIAGNOSIS _____		68. E. RENDERING PROVIDER ID # _____	
69. A. DATE OF SERVICE From MM DD YY To MM DD YY		69. B. PLACE OF SERVICE _____		69. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		69. D. DIAGNOSIS _____		69. E. RENDERING PROVIDER ID # _____	
70. A. DATE OF SERVICE From MM DD YY To MM DD YY		70. B. PLACE OF SERVICE _____		70. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		70. D. DIAGNOSIS _____		70. E. RENDERING PROVIDER ID # _____	
71. A. DATE OF SERVICE From MM DD YY To MM DD YY		71. B. PLACE OF SERVICE _____		71. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		71. D. DIAGNOSIS _____		71. E. RENDERING PROVIDER ID # _____	
72. A. DATE OF SERVICE From MM DD YY To MM DD YY		72. B. PLACE OF SERVICE _____		72. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		72. D. DIAGNOSIS _____		72. E. RENDERING PROVIDER ID # _____	
73. A. DATE OF SERVICE From MM DD YY To MM DD YY		73. B. PLACE OF SERVICE _____		73. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		73. D. DIAGNOSIS _____		73. E. RENDERING PROVIDER ID # _____	
74. A. DATE OF SERVICE From MM DD YY To MM DD YY		74. B. PLACE OF SERVICE _____		74. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		74. D. DIAGNOSIS _____		74. E. RENDERING PROVIDER ID # _____	
75. A. DATE OF SERVICE From MM DD YY To MM DD YY		75. B. PLACE OF SERVICE _____		75. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		75. D. DIAGNOSIS _____		75. E. RENDERING PROVIDER ID # _____	
76. A. DATE OF SERVICE From MM DD YY To MM DD YY		76. B. PLACE OF SERVICE _____		76. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		76. D. DIAGNOSIS _____		76. E. RENDERING PROVIDER ID # _____	
77. A. DATE OF SERVICE From MM DD YY To MM DD YY		77. B. PLACE OF SERVICE _____		77. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		77. D. DIAGNOSIS _____		77. E. RENDERING PROVIDER ID # _____	
78. A. DATE OF SERVICE From MM DD YY To MM DD YY		78. B. PLACE OF SERVICE _____		78. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		78. D. DIAGNOSIS _____		78. E. RENDERING PROVIDER ID # _____	
79. A. DATE OF SERVICE From MM DD YY To MM DD YY		79. B. PLACE OF SERVICE _____		79. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		79. D. DIAGNOSIS _____		79. E. RENDERING PROVIDER ID # _____	
80. A. DATE OF SERVICE From MM DD YY To MM DD YY		80. B. PLACE OF SERVICE _____		80. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		80. D. DIAGNOSIS _____		80. E. RENDERING PROVIDER ID # _____	
81. A. DATE OF SERVICE From MM DD YY To MM DD YY		81. B. PLACE OF SERVICE _____		81. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		81. D. DIAGNOSIS _____		81. E. RENDERING PROVIDER ID # _____	
82. A. DATE OF SERVICE From MM DD YY To MM DD YY		82. B. PLACE OF SERVICE _____		82. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		82. D. DIAGNOSIS _____		82. E. RENDERING PROVIDER ID # _____	
83. A. DATE OF SERVICE From MM DD YY To MM DD YY		83. B. PLACE OF SERVICE _____		83. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		83. D. DIAGNOSIS _____		83. E. RENDERING PROVIDER ID # _____	
84. A. DATE OF SERVICE From MM DD YY To MM DD YY		84. B. PLACE OF SERVICE _____		84. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		84. D. DIAGNOSIS _____		84. E. RENDERING PROVIDER ID # _____	
85. A. DATE OF SERVICE From MM DD YY To MM DD YY		85. B. PLACE OF SERVICE _____		85. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		85. D. DIAGNOSIS _____		85. E. RENDERING PROVIDER ID # _____	
86. A. DATE OF SERVICE From MM DD YY To MM DD YY		86. B. PLACE OF SERVICE _____		86. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		86. D. DIAGNOSIS _____		86. E. RENDERING PROVIDER ID # _____	
87. A. DATE OF SERVICE From MM DD YY To MM DD YY		87. B. PLACE OF SERVICE _____		87. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		87. D. DIAGNOSIS _____		87. E. RENDERING PROVIDER ID # _____	
88. A. DATE OF SERVICE From MM DD YY To MM DD YY		88. B. PLACE OF SERVICE _____		88. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		88. D. DIAGNOSIS _____		88. E. RENDERING PROVIDER ID # _____	
89. A. DATE OF SERVICE From MM DD YY To MM DD YY		89. B. PLACE OF SERVICE _____		89. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		89. D. DIAGNOSIS _____		89. E. RENDERING PROVIDER ID # _____	
90. A. DATE OF SERVICE From MM DD YY To MM DD YY		90. B. PLACE OF SERVICE _____		90. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		90. D. DIAGNOSIS _____		90. E. RENDERING PROVIDER ID # _____	
91. A. DATE OF SERVICE From MM DD YY To MM DD YY		91. B. PLACE OF SERVICE _____		91. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		91. D. DIAGNOSIS _____		91. E. RENDERING PROVIDER ID # _____	
92. A. DATE OF SERVICE From MM DD YY To MM DD YY		92. B. PLACE OF SERVICE _____		92. C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual Circumstances)		92. D. DIAGNOSIS _____			

**IN THE CIRCUIT COURT FOR DAVIDSON COUNTY, TENNESSEE
AT NASHVILLE**

**ANGELICA CRUZ-ROMO and
ROGELIO GARCIA**

Plaintiffs,

v.

**PUBLIX SUPER MARKETS INC a/d/b/a)
PUBLIX ASSET MANAGEMENT)
COMPANY, and PUBLIX TENNESSEE)
LLC.)**

Defendant.)

Docket No: _____

**PLAINTIFF'S FIRST SET OF INTERROGATORIES AND
REQUESTS FOR PRODUCTION TO THE DEFENDANT PUBLIX ASSET
MANAGEMENT COMPANY**

I hereby serve upon the Defendant, Publix Asset Management Company(Hereinafter "Publix AMC") the following written Interrogatories and Request for Production of Documents under the provisions of Rule 33 and 34 of the Tennessee Rules of Civil Procedure.

You are required to answer these interrogatories separately and fully in writing under oath and to serve a copy of your answers on the undersigned attorney within thirty days (30) days after service hereof.

These interrogatories shall be continuing in nature until the date of trial, and you are required to serve supplemental answers as additional information may become available to you as required by Rule 26.05 of the Tennessee Rules of Civil Procedure.

DEFINITIONS AND INSTRUCTIONS

As used in these Interrogatories and Request for Production of Documents served herewith, the following definitions and instructions shall apply:

(1) As used herein, the terms “you,” “your,” or “yourself” refer to the defendant, and each agent, representative, attorney, or other person acting or purporting to act for said defendant.

(2) As used herein, the term “person” means any natural individual in any capacity whatsoever or any entity or organization, including divisions, departments, and other units therein, and shall include, but not be limited to, a public or private corporation, partnership, joint venture, voluntary or unincorporated associated organization, proprietorship, trust, estate, governmental agency, commission, bureau, or department.

(3) As used herein, the term “identification,” “identify,” or “identity” when used in reference to (a) a natural individual, requires you to state his or her full name and residential and business address, and his or her present or last known residence and business telephone numbers; (b) a corporation, requires you to state its full corporate name and any names under which it does business, its state of incorporation, the address of its principal place of business, and the name and address of its registered agent for service of process within the State of Tennessee; or (c) a business, requires you to state the full name under which the business is conducted, its business address, the types of businesses in which it is engaged, and the identity of the person, or persons, who own, operate, and control the business.

(4) As used herein, the term “communication” means any oral or written utterance, notation, or statement of any nature whatsoever, by and to whomsoever made, including, but not limited to, correspondence, conversations, dialogues, discussions, interviews, consultations, agreements, and other understandings between or among two or more persons, by any means or made of conveying information, including but not limited to telephone, television, or telegraph.

(5) As used herein, the term “document” means any medium upon which information can be recorded or retrieved, and includes, without limitation, the original and each copy, regardless of origin and location, of any book, pamphlet, periodical,

letter, memorandum, invoice, bill, order form, receipt, financial statement, accounting entry, diary, calendar, telex, fax, telegram, cable, report, record, contract, agreement, study, handwritten note, draft, working paper, chart, paper, print, laboratory record, drawing, sketch, graph, index, list, tape, photograph, microfilm, data sheet, or any other written, recorded, transcribed, punched, taped, filmed, or graphic matter, however produced or reproduced, which is in your possession, custody, or control, or which was, but is no longer, in your possession, custody, or control.

(6) As used herein, the word “or” appearing in an interrogatory should not be read so as to eliminate any part of the interrogatory, but, whenever applicable, it should have the same meaning as the word “and”.

(7) With regard to the terms defined herein, all terms used in the singular shall include the plural, and all terms used in the plural shall include the singular.

(8) If any privilege is claimed with respect to any document or communication, identify the document or communication and state the privilege claimed and the basis therefore.

INTERROGATORIES

1. For the person or persons answering these Interrogatories, please state your full name, age and date of birth, current address and any prior addresses at which you have lived during the past ten years. For each prior address, state the duration you lived there and why you moved. If more than one person participated in answering these Interrogatories, please state which Interrogatories each person answered.

RESPONSE:

2. For each person or persons answering these Interrogatories, please state your position of employment and your relationship to the Defendant.

RESPONSE:

3. Identify each person with whom you consulted, upon whom you relied, or who otherwise constituted a source of information for you in connection with the preparation of your answers to these Interrogatories, listing with respect to each such person the number(s) of the interrogatories to which such person was consulted, was relied upon, or otherwise constituted a source of information.

RESPONSE:

4. State when accident or injuries which are the subject of this Complaint first came to the attention of Defendant Publix AMC or any representatives, of Publix AMC, by whom it was reported, and to whom it was reported. Please state whether any incident report, report of injury, insurance claim report, or accident report(s) was filled out, and provide a copy of said report(s).

RESPONSE:

5. State whether or not any statement, interview, or report has been secured from the Plaintiff, and or any agent, employee, and/ as servant of Publix AMC; in

connection with this matter, by the Defendant and/ or any agent of the Defendant, including insurance companies. If so, please identify the date, place, and time the statement, interview, or report was taken; the name and address of the persons giving the statement, report or interview; the name of the persons(s) taking the report, statement and/ or interview along with the interviewers address; whether the statement was oral, written, taped, recorded, or transcribed; whether the statement, report and/ or interview was signed; and upon whose behalf the statement, interview, or report was taken or made. Please attach a copy of any recorded or written statement taken from the Plaintiff as an additional Request for Production of Document to Defendant Publix AMC. If no recorded or written statement was kept, please provide a detailed description of all information provided to you by and/ or any agent(s), employee(s) and or servant(s) by the Plaintiff and/ or connected in any way to the event causing injury to the Plaintiff, Angelica Cruz-Romo, on January 30, 2021.

RESPONSE:

6. Identify by name, address, telephone number, and relationship to any party in this lawsuit all persons believed by you to have knowledge of any discoverable evidence or information relating to either the alleged accident itself or to either the Plaintiff's or your claims for damages in this lawsuit. As part of your response, for each witness so identified briefly describe what discoverable evidence or information said witness is believed to know.

RESPONSE:

7. Identify all persons who the Defendant believes to be in possession of, or to have knowledge of, any map, picture, photograph, drawing, or other document relevant to any issue or fact concerning the incident, including the Plaintiff's injuries or any claim that the Plaintiff or some other entity was at fault for said injuries. In identifying said persons, specify name, address, telephone number, and relationship to any party.

RESPONSE:

8. Describe in detail every other accident or injury which has occurred on the common areas of the premises of the Defendant, during any time when said premises have been under the possession or control of the Defendant within the last ten years. Include the date, time, the nature of any alleged injuries, the alleged cause of said injuries, whether any claim or Complaint was filed or reported against Publix AMC, and if so, the disposition of said claim or Complaint.

RESPONSE:

9. Please state the names and addresses of every person known by Defendant Publix AMC, Defendant's representatives, agents, employee(s) and/ or Servants or Defendants attorneys to have witnessed the accident which is the subject of this Complaint, or who were present at the scene within sixty minutes before or after the accident. Designate the witnesses name along with their respective address who which of

such people claim to have witnessed the accident and please provide a synopsis and/ or summary of any statement, interview, and/ or report given or taken from any of these witnesses to the accident. As an additional request for Request for Production of Document to Defendant Publix AMC, please attach a copy of any recorded and/ or written statement taken from any and all witnesses to this accident which is the subject of the pending complain in this matter.

RESPONSE

10. List each of the following:
 - (a) The names and addresses of those persons who have given to you, your attorney, or any person, firm or corporation acting on your behalf, any statements, accident reports, interview, voice recordings, video recordings, tape recording, digital recordings, medical proof of claim forms, reports, or memoranda in any way concerning the incident described in the complaint which is pending in this matter.
 - (b) The name, telephone number, and address of the person, firm or corporation who now has possession of same.

RESPONSE:

11. For each person whom you expect to call as an expert witness at trial, whether the witness is a retained expert or non-retained expert, please state the following:

- (a) The expert's full name, business address and telephone number;
- (b) The expert's occupation;
- (c) The subject matter on which the expert is expected to testify and the expert's hourly deposition fee;
- (d) The substance of the facts and opinions to which the expert is expected to testify, including a summary of the grounds for each opinion; and
- (e) The expert's qualifications to give an opinion (if such information is available on the expert's curriculum vitae, you may attach a copy thereof in lieu of answering this interrogatory subpart).

RESPONSE:

12. List the names, addresses, phone numbers, training of any persons, and resume and/ or curriculum vitae trained in analyzing, inspecting, investigating, observing, or making calculations based upon accident sites or related factors who have inspected, observed, or otherwise been in contact with the premises upon which the accident which is the subject of this Complaint occurred. Please also give the dates on which such persons observed and/ or review the accident site premises, what physical evidence was observed, what measurements were made, what opinions were formed, and

what tests were performed. In the event that a report, memorandum, and/ or any document has been created as result of such observation and/ or review, as an additional Request for Production of Document to Defendant Publix AMC, please attach a copy of said memorandum, report and/ or other document.

RESPONSE:

13. With regard to the incident, injuries or accident alleged in the Complaint, state in detail, and in your own words, your understanding of how the Plaintiff's accident and injuries occurred. Your response must include the following:

- (a) Where on the premises the Plaintiff was at the time of the accident;
- (b) What caused the accident to occur;
- (c) Who you believe to be the at fault party;
- (d) Who was present when Plaintiff was injured;
- (e) Who was notified of the Plaintiff's injury;
- (f) What kind of injuries Plaintiff suffered as a result of the accident, and whether Plaintiff received medical treatment for said injuries.

RESPONSE:

14. Describe in detail any conversation or discussion Defendant, Publix AMC or any agent, employee and/ or servant of Defendant, Publix AMC may have had with the Plaintiff, witnesses, or other persons having any information whatsoever regarding the incident which is the subject of this Complaint or the Plaintiff's injuries. Your

response must include the names of all parties to the conversation, if known, as well as a recitation of what was said, and the date upon which the conversation took place.

RESPONSE:

15. Have you, or any person acting on your behalf, obtained any letter, note, correspondence, computer report, official record, or other document or record relating to the medical condition of the Plaintiff or any prior accidents or injuries which may have involved the Plaintiff? If so, identify such document or record.

RESPONSE:

16. Have you or anyone working on your behalf, or on behalf of any representative of yours, made any attempt to survey, observe, photograph, and/or record, by any means, the Plaintiff to this action? If so, describe the result of the attempts, the dates of these attempts, and the identity of all individuals making such attempts. Please provide complete copies of all documents, exhibits, photographs, movies, videotapes, maps, recordings, charts, drawings, diagrams, and/or computer-generated renderings, that

depict the Plaintiff, made by the individuals identified in response to this Interrogatory. Please note that this Interrogatory is continuing in nature and must be supplemented promptly if any attempt is made before trial to survey, observe, photograph, and/or record the Plaintiff by any means.

RESPONSE:

17. Please state the name and address of any potential party to this lawsuit, not already named as a party hereto.

RESPONSE:

18. Is it your contention that any negligence or fault on the part of the Plaintiff caused or contributed to the accident or injuries which are the subject of this Complaint? If so, identify and describe in detail every fact or belief which supports your contention.

RESPONSE:

19. Is it your contention that any negligence or fault on the part of any person or entity not already a party to this action caused or contributed to the accident or injuries which are the subject of this Complaint? If so, identify and describe in detail every fact or belief which supports your contention.

RESPONSE:

20. Is it your contention that Plaintiff's accident or injuries were related to or caused by a hazard on Defendant Publix AMC premises and/ or on the premises of any other Defendant or person not named as a Defendant in this lawsuit. If so, please state the premises owner and/ or person or entity in control of the premises where this accident occurred which is the subject of this complaint. In addition, do you contend that the hazard causing injury to the Plaintiff was open and obvious? which was open or obvious? If so, identify and describe in detail every fact which supports your contention, and state how long the open and obvious hazard or condition had existed on Defendant's premises. If your reply is that Defendant does not know how long the open and obvious hazard existed on the premises, explain in detail why Defendant does not know how long the hazard existed on the premises.

RESPONSE:

21. Is it your contention that Plaintiff Angelica Cruz-Romo's injuries and/or medical treatment is not causally related to this incident on the Defendant's premises? If so, identify and describe in detail every fact or belief which supports your contention.

RESPONSE:

22. Please provide the name, home address, telephone number, and current employer (if known) of all persons working in the capacity of a security guard on the Defendant's premises at the time of the incident alleged in the Complaint.

RESPONSE:

23. Please provide any tape, video, audio, and/ or digital recording that could in any way depict the event(s) given rise to the subject of the complaint in this matter as and additional Request for Production of Documents.

OATH

STATE OF TENNESSEE

COUNTY OF _____

_____, being first duly sworn,
hereby makes oath and avers that he/she attests the foregoing responses to the
Interrogatories and Request for Production of Documents on behalf of Publix Asset
Management Company in his/her capacity as _____, participated
in the preparation of same, and that all of the statements made contained therein are true
and complete to the best of his/her knowledge, information and belief.

[Defendant]


Title

Sworn to and subscribed before me on this the _____ day of _____,
20____.

NOTARY PUBLIC

My Commission Expires:

Respectfully submitted,


MICHAEL K PARSLEY, BPR # 023817
Michael D. Ponce & Associates
Attorneys for Plaintiff
400 Professional Park Drive
Goodlettsville, TN 37072
Telephone: (615) 851-1776

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been served via email, facsimile, hand delivery, and or U.S. First Class Mail, postage prepaid, addressed as follows:

This 6th day of December, 2021.


MICHAEL K PARSLEY, BPR # 023817

**PLAINTIFFS' FIRST REQUEST FOR
PRODUCTION OF DOCUMENTS TO DEFENDANT**

Plaintiff requests that the Defendant produce the following documents pursuant to Rules 26 and 34 of the Tennessee Rules of Civil Procedure.

1. Please produce all documents referred to, identified, or used in answering the Interrogatories set forth above.

RESPONSE:

2. Please produce copies of any and all photographs, diagrams, maps, movies, or videos in your possession that depict the area of the premises in which the Plaintiff Angelica Cruz-Romo claims to have been hit. State when, where, why, and by whom said materials were taken or drawn.

RESPONSE:

3. Please produce all documents and exhibits, photographs, movies, video tapes, charts, recordings, or maps on which you are relying to answer the above Interrogatories and Request for Production of Documents, and/or which you plan to present, even if only as demonstrative evidence, at the trial of this matter.

RESPONSE:

4. Please produce all documents, exhibits, photographs, movies, videotapes, surveillance tapes, maps, recordings, charts, drawings, diagrams, and/or computer-generated renderings in your possession that depict the Plaintiff either before or after the accident that is described in the Complaint.

RESPONSE:

6. If you intend to call an expert witness (witnesses) to testify in this case, please produce the following with respect to each such witness:

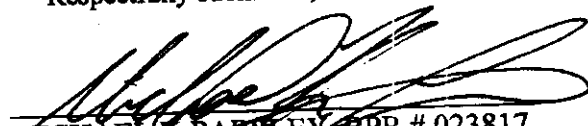
- (a) A current and complete resume or curriculum vitae for the witness;
- (b) A list of all cases the witness has testified in by way of oral deposition or trial testimony, including the name(s) of the attorney(s) who called the witness, during the five (5) year period immediately preceding your response;

- (c) Produce a list of all compensation received by the witness, including Internal Revenue Service 1099 Forms for all compensation received by the witness, for providing inspections, consulting, reports, depositions, and trial testimony for all defendants, defense law firms, and/or automobile liability insurance companies during the ten (10) year period immediately preceding your response.
- (d) Produce a list of all compensation received by the witness, including Internal Revenue Service 1099 Forms for all compensation received by the witness, for providing inspections, consulting, reports, depositions, and trial testimony for all plaintiffs and/or plaintiffs law firms during the ten (10) year period immediately preceding your response.
- (e) All raw facts, information, and/or data, including all notes, tests, photographs, videotapes, audio tapes, results, measurements, computer information, data or computer disks or hard drives, or any other information which in any way was relied upon by the witness in preparation of his/her report, analysis, reconstruction, or in the formulation and preparation of the opinions and conclusions contained therein, or which form the basis of his/her opinion(s) which you intend to offer at the trial of this case;
- (f) Copies of any and all literature, journal articles, treatises, technical papers or any other written and/or computer generated material or information of any type relied upon in any way in the preparation of the witness' report,

analysis, reconstruction, or which form the basis of his/her opinion(s)
which you intend to offer at the trial of this case.

RESPONSE:

Respectfully submitted,

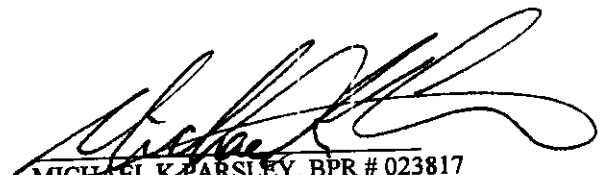


MICHAEL K. PARSLEY, BPR # 023817
Michael D. Ponce & Associates
Attorneys for Plaintiff
400 Professional Park Drive
Goodlettsville, TN 37072
Telephone: (615) 851-1776

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been served via email, facsimile, hand delivery, and or U.S. First Class Mail, postage prepaid, addressed as follows:

This 6th day of December 20 21.



MICHAEL K. PARSLEY, BPR # 023817

DEC 13 2021